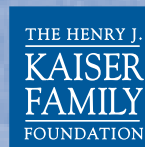


How States Are Responding to the Challenge of Financing Health Care for Retirees

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Executive Summary

As employers, state governments are an important source of health insurance coverage to retired state employees. Like the federal government and many private employers, state governments offer health benefits that fill gaps in Medicare's benefits package for retirees who are 65 and older, and provide basic health care coverage to workers who retire before they turn 65 and become eligible for Medicare. Over the past decade, there has been a steady erosion of retiree health benefits among private-sector employers, with both fewer employers offering retiree health benefits and more employers cutting back on the breadth of the benefits offered.¹ Confronted with rising health care costs, budget deficits, and an overall downturn in the economy, it is unclear how states are responding to the challenge of financing health care for retirees who tend to be sicker and more costly to cover than active workers. This study, conducted by researchers at Georgetown University, was designed to capture information on retiree health programs offered by state governments, including benefits, premiums, recent program changes, and modifications expected in the future.

The survey collected data and information primarily through telephone interviews conducted between July and October 2002, with state officials who administer retiree health programs. Responses were provided by 43 states and the District of Columbia. Including dependents, states participating in this study represent about 1.8 million covered lives, which projects to about 2 million covered lives nationwide. If separate systems for covering local government employees or schoolteachers were added, the total number of covered lives in state-based retiree health systems is estimated to be at least 2.25 million. Approximately three-fourths of these covered lives are Medicare-eligible retirees (age 65 and older or disabled), and the rest are early retirees (under 65).

Findings

Eligibility: Every state makes health benefits available to early retirees (< 65 years of age), and all but one offers health benefits to Medicare-eligible retirees (age 65 and older or disabled). In addition to covering state government retirees, the state retiree health systems often cover those who worked for state universities and colleges, and in some cases those who worked as public schoolteachers and local government employees. Eligibility for benefits varies enormously, with most states applying either a combined age and service requirement (for example, age 55 with 20 years of service) or a straight service requirement. Many states require an individual to be drawing a pension in order to be eligible for retiree health benefits.

Premiums: There is considerable state variation in the share of the total premium that is paid by the states and the share of premium that is paid by retirees. For example, about one-fourth of responding states (12), representing 44 percent of Medicare-age retirees, fully subsidize coverage and require Medicare-age retirees to pay nothing toward the premium. Another quarter of states (12), representing nine percent of Medicare-age retirees, pay nothing toward the

¹ Henry J. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2002 Annual Survey*, 2002; Henry J. Kaiser Family Foundation and Hewitt Associates, *The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey*, December 2002.

premium, requiring Medicare-age retirees to pay the full cost of coverage. States that require retirees to pay the full cost of coverage offer group rates, but retirees are responsible for the entire premium (weighted average of \$222 per month). In the remaining states, costs are divided in varying proportions between the states and their retirees. Among states where retirees pay at least some portion of the premium, Medicare-age retirees pay an average of 37 percent of the premium (\$96 per month). Five larger northeastern states (as well as California, for some retirees) pay the Medicare Part B premium for retirees 65 and older in addition to paying for some or all of their supplemental coverage.

The total cost of retiree health benefits varies considerably by size of state, with total monthly premium costs for Medicare-age retirees averaging about \$189 in the smaller states and \$257 in the larger states. Likewise, the amount paid by the retiree out-of-pocket also varies by size of state. Medicare-age retirees' contributions to premiums average about \$103 per month in smaller states and about \$55 in larger states, which typically pass along a smaller share of the premium to the retiree.

The average cost of coverage for those state Medicare-eligible retirees who pay a premium (\$96 per month) is modestly higher than the premium cost faced by their counterparts in the private sector (\$79 per month) and the federal government (\$89 per month) for the largest plan.² However, including the 12 states where retirees pay no premium, the total average cost of coverage for all state Medicare-eligible retirees is \$55 a month, well below the premium for retirees receiving coverage from large private employers or the federal government.

Plan Options and Benefits: State retirees can generally choose among several different types of plans, with only seven states offering just a single plan option. Most states offer at least one health maintenance organization (HMO) and at least one preferred provider organization (PPO), while nearly half of the states offer an indemnity plan. Enrollment tends to be heavily concentrated in less managed plans, with about one third of enrollees in PPOs and another third in indemnity plans. A majority of states have deductibles in their largest plan (averaging \$235) and place limits on retirees' annual out-of-pocket costs (averaging \$1,650). In large states, plans with the greatest enrollment are slightly more likely to have deductibles and out-of-pocket limits.

Prescription Drugs: Coverage for prescription drugs is one of the most important components of the benefit package for retirees, especially for Medicare-age retirees who at present do not have an outpatient drug benefit from Medicare. The states typically include fairly generous coverage for drugs: only one state places a dollar limit on the drug benefit and seven states impose a separate deductible for drugs (ranging from \$25 to \$250). Fourteen states limit out-of-pocket cost-sharing for drugs (average limit just over \$1,000). Most states apply a two-tiered or three-tiered system of copayments for prescription drugs, while 10 states use coinsurance percentages that range from 10 to 50 percent. Typically, states provide coverage for drugs purchased at retail pharmacies and through mail-order pharmacies, but eight states cover only drugs purchased at retail pharmacies.

² Kaiser/Hewitt 2002 Retiree Health Survey, December 2002; Office of Personnel Management, 2002 FEHB Non-Postal Fee-for-Service Premium Rates, www.opm.gov/insure/health/02rates/nonpostal_ffs.htm.

Recent Changes: Rising health care costs are challenging the ability of the states to maintain generous retiree health benefits. Overall, nearly every state has taken some kind of action to control costs, including changes to benefits or administrative procedures or higher cost-sharing requirements for their retirees. However, no state has terminated subsidized health benefits for current or future retirees.

Drug costs are frequently cited as the largest single contributor to rising costs, and as a result many states have responded by increasing the cost-sharing requirements paid by beneficiaries, increasing financial incentives to use generic and preferred brand-name drugs, and requiring prior authorization for certain drugs to reduce the growth in spending.

Future Changes: Looking ahead, state officials expect to continue making adjustments to their retiree health benefits to hold down the rising costs of health care, especially prescription drugs. But officials made it clear that they do not anticipate taking such drastic steps as eliminating benefits entirely, as observed among private-sector employers. Since prescription drugs are viewed as the largest area of cost pressure, states said they are more likely to make changes in this area than they are for other health benefits. New drug cost-sharing requirements, new utilization management strategies, and further incentives to increase the use of generic drugs were cited as the most likely changes expected in the next few years.

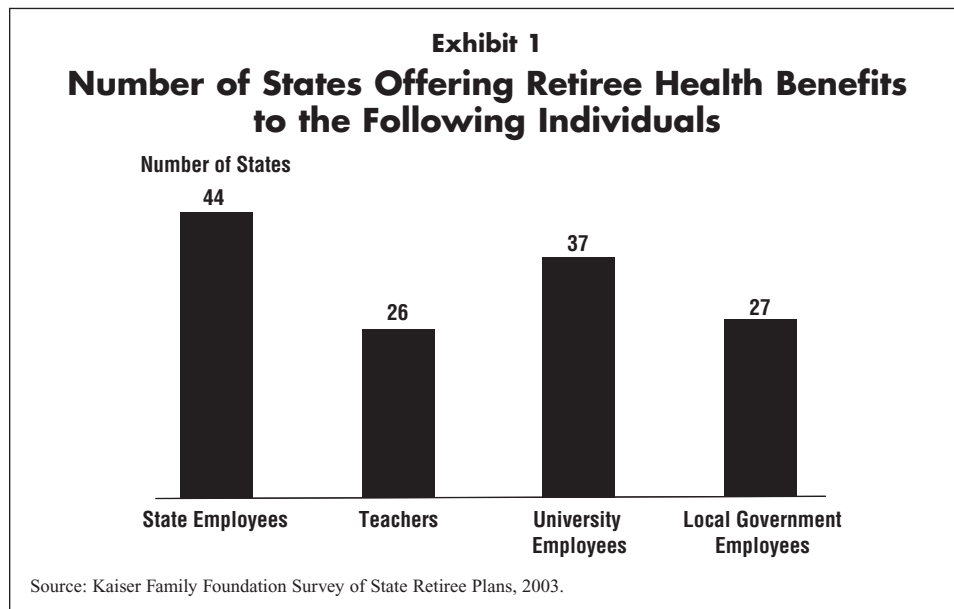
I. Availability, Eligibility, and Administration

States Offering Retiree Health Benefits

All states make health benefits available to early retirees (<65 years old), and all but one offer health benefits to Medicare-eligible retirees (65 and older or disabled).³ This is fairly commensurate with offer rates observed among large private-sector employers. According to the Kaiser/Hewitt 2002 Survey on Retiree Health Benefits, 91 percent of large, private-sector firms offered retiree health benefits to both pre-65 and post-65 retirees in 2002.⁴

Eligibility of Different Groups

The reach of state retiree health programs goes considerably beyond those individuals who were formerly employed in state government. Most states include at least some employees of state universities and colleges, and more than half of the states include public schoolteachers and local government employees, although participation of these groups may be at the option of the local government or school system (Exhibit 1). Spouses and dependents of retirees are covered as well, and that coverage continues in most cases after the death of the retiree. Among the 44 responding states, 42 states covered spouses and dependents, and 38 covered surviving spouses.



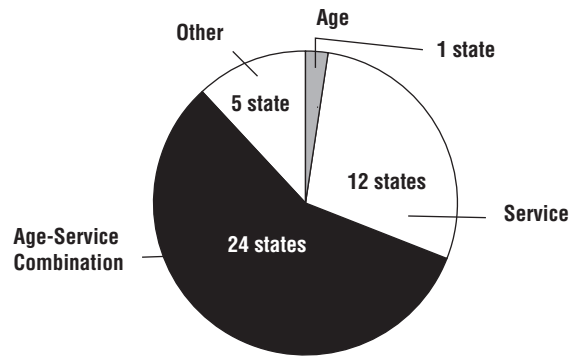
Age and Service Eligibility Criteria

Eligibility varies enormously, with most states applying either a combined age and service requirement (for example, age 55 with 25 years of service) or a straight service requirement

³ In this report, the District of Columbia is generally included under the term “state.” As reported in the methodological appendix, 43 states and the District of Columbia responded to the survey. Some states did not respond to all questions.

⁴ Henry J. Kaiser Family Foundation and Hewitt Associates, *The Current State of Retiree Health Benefits: Findings from the Kaiser/Hewitt 2002 Retiree Health Survey*, December 2002.

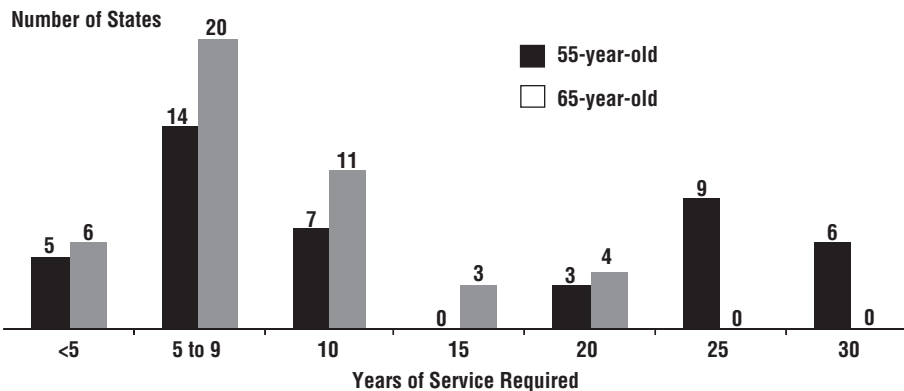
Exhibit 2
Eligibility Criteria for State Retiree Health Benefits



Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

(Exhibit 2). Many states indicated that eligibility for health benefits follows pension eligibility, meaning an individual must be drawing a pension in order to be eligible for retiree health. These eligibility requirements are further linked to the presence of state subsidies for coverage. Where the state pays for at least a portion of the coverage, the state often imposes stricter eligibility requirements to receive the subsidy. It is difficult to generalize given wide state variations, but the median number of years for a 55-year-old retiree to be eligible for benefits (but not necessarily subsidized) is 10 years (mean = 14 years). For a 65-year-old retiree, the median number of years required is 5 years (mean = 8 years). A few states require as many as 20 years for a 65-year-old retiree to be eligible for benefits. And nearly half the states responding require 20 to 30 years of service for a 55-year-old retiree to be eligible for benefits (Exhibit 3).

Exhibit 3
Years of Employment Required for a State Employee to be Eligible for Retiree Health Benefits



Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

Platform for Offering Benefits

The platform for offering benefits to retirees varies somewhat across states. In many states, the same agency or office arranges benefits for both active employees and retirees. While some of the specific offerings may vary (particularly for Medicare-eligible retirees), these states tend to run their benefits as a single system. In some states, however, retiree benefits are managed as a completely separate system. Administration of the system in some cases, is conducted by an agency in one of the state executive departments. In other cases, systems are managed by a freestanding agency, such as the California Public Employees' Retirement System. Those states that operate a self-funded preferred provider organization (PPO) or indemnity plan are particularly likely to have a separate agency that runs the system.

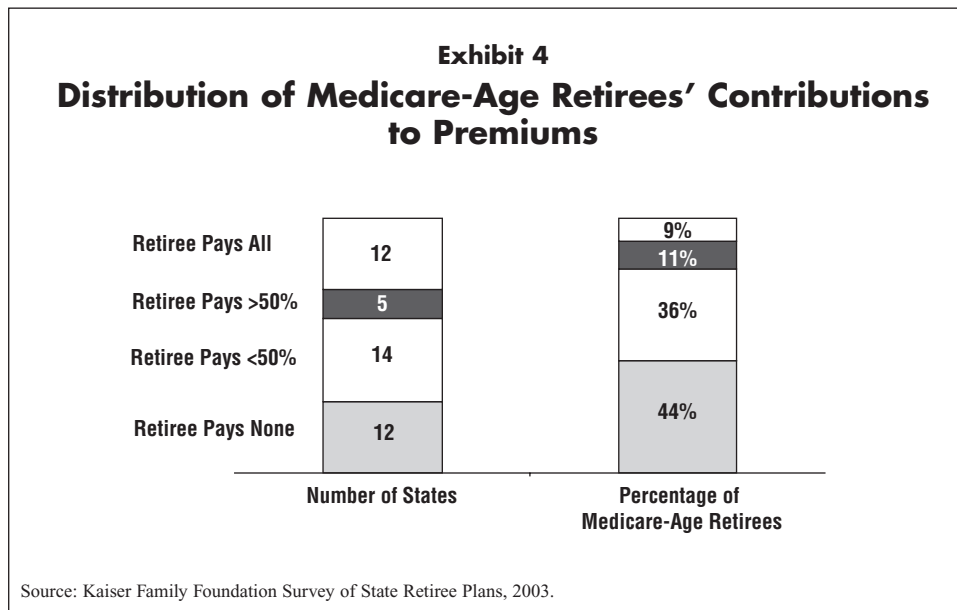
II. Who Pays for Retiree Coverage?

There is substantial variation across states in retiree health premiums, including both the share of the premium paid by the state and the share paid by the retiree. At one extreme, some states fully subsidize the coverage. At the other extreme, some states pass the full cost of the premium on to the retirees. These retirees get the advantage of group rates, which are substantially lower than individual rates, but must pay the full cost of the premium out-of-pocket. In some cases, especially for early retirees, states pool the retirees with their active employees, thus cross-subsidizing premium rates.

Medicare-Age Retirees

Retiree Contributions to Premium Costs

Over one-fourth of responding states (12)—representing 44 percent of all Medicare-age retirees—pay the entire cost of coverage for Medicare-age retirees (Exhibit 4). Another quarter of responding states (12) require Medicare-age retirees to pay the entire cost of the premium. The states that leave premium costs to retirees tend to be smaller states representing only about 9 percent of Medicare-age retirees.⁵ Fourteen states, representing over one-third of Medicare-age retirees require them to pay up to 50 percent of premium costs.



Determining State and Retiree Contributions to Premiums

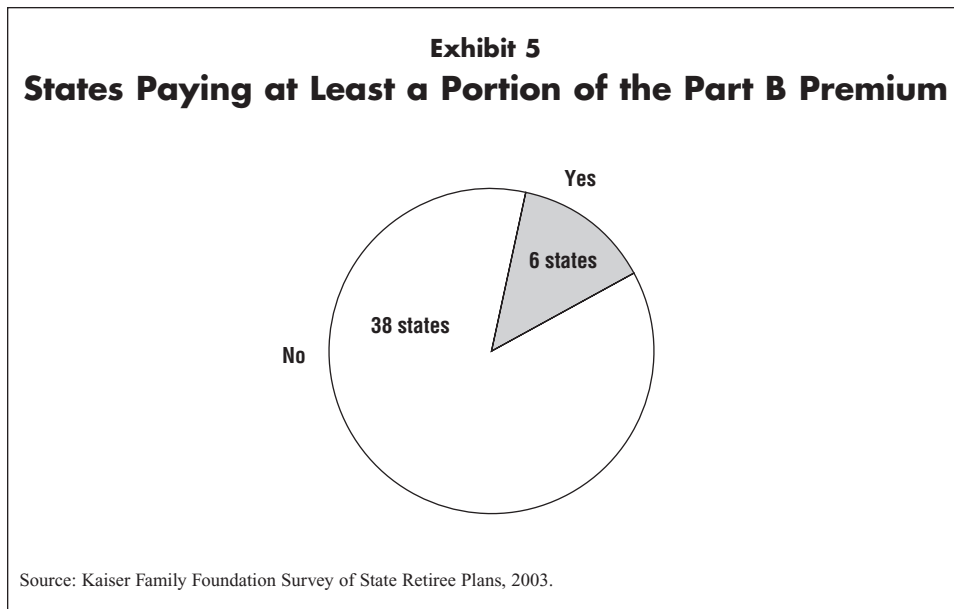
The state and retiree contributions to premiums are determined in very different ways across the states. Some states have a simple formula set by statute, while others have a dollar amount established. California's statute, for example, requires that the state pay 100 percent of a weighted average premium (using the four plans with largest enrollment) and 90 percent

⁵ Technically, this is a count of states weighted by the total number of retirees.

of the additional premiums for their dependents, with additional variations based on years of state employment.

Payment of the Part B Premium

Another six states go a step further and pay for all or most of the retiree's Medicare Part B premium, in addition to paying for the supplemental coverage, for at least some of their retirees (Exhibit 5). Five northeastern states, representing nearly one-third (29 percent) of the retirees in the states responding to this survey, pay for all or most of the Part B premium for their retirees. In addition, California contributes to the Part B premium to the extent that the state's defined contribution toward the premium cost exceeds the cost of a particular health plan. Thus, in 2002, the state paid the Part B premium for enrollees in Kaiser Permanente, whereas enrollees in the PPO sponsored by the Public Employees Retirement System paid their own Part B premium.

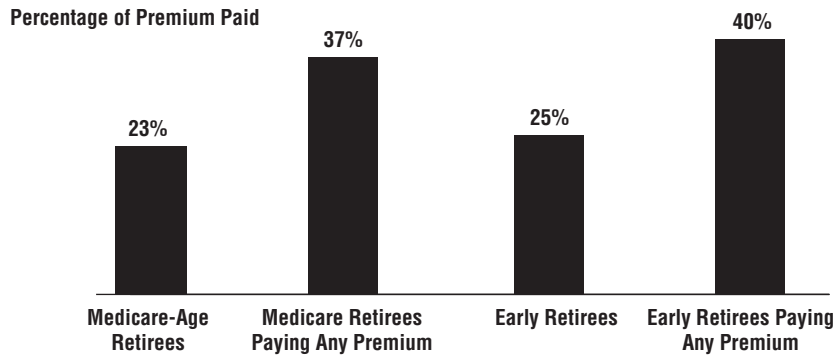


Total Premium Costs for Retirees

State retirees on Medicare pay for about 23 percent of total premium costs for single coverage, on average. This compares to the national average of 16 percent for active workers across all employers (Kaiser/HRET survey), and to 40 percent for retirees of large, private-sector firms (2002 Kaiser/Hewitt survey).⁶ Considering only those states where retirees pay at least some portion of the premium, Medicare-age retirees pay an average of 37 percent of the premium (Exhibit 6).

⁶ Henry J. Kaiser Family Foundation and Health Research & Educational Trust, *Employer Health Benefits: 2002 Annual Survey*, September 2002; Kaiser/Hewitt, December 2002.

Exhibit 6
Average Percentage of Premium Paid by Medicare-Age Retirees and Early Retirees

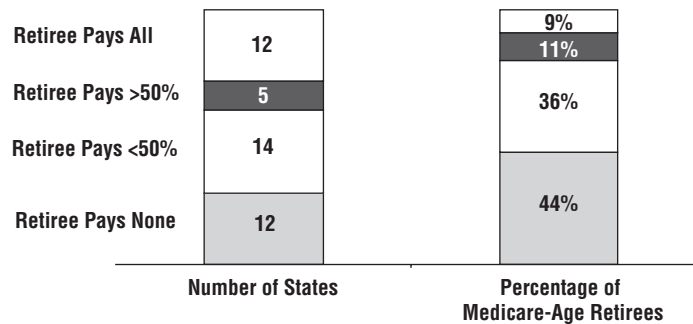


Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

Early Retirees

The picture is modestly different for early retirees. Fewer responding states (9) pay the entire cost of coverage for early retirees than do so for Medicare-age retirees (Exhibit 7). On average, early retirees pay 25 percent of total premium costs, a slightly higher share than the 23 percent paid by Medicare-age retirees and well below the 42 percent that early retirees pay for private coverage offered by large firms (2002 Kaiser/Hewitt survey). Early retirees who pay at least a portion of the premium pay an average of 40 percent of the total premium (Exhibit 6).

Exhibit 7
Distribution of Medicare-Age Retirees' Contributions to Premiums

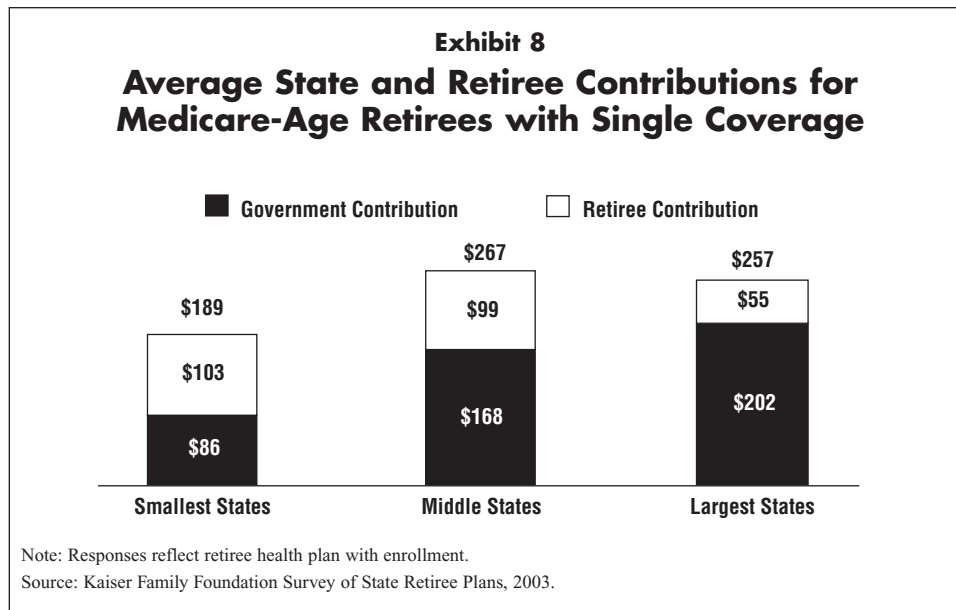


Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

III. The Cost of Retiree Coverage

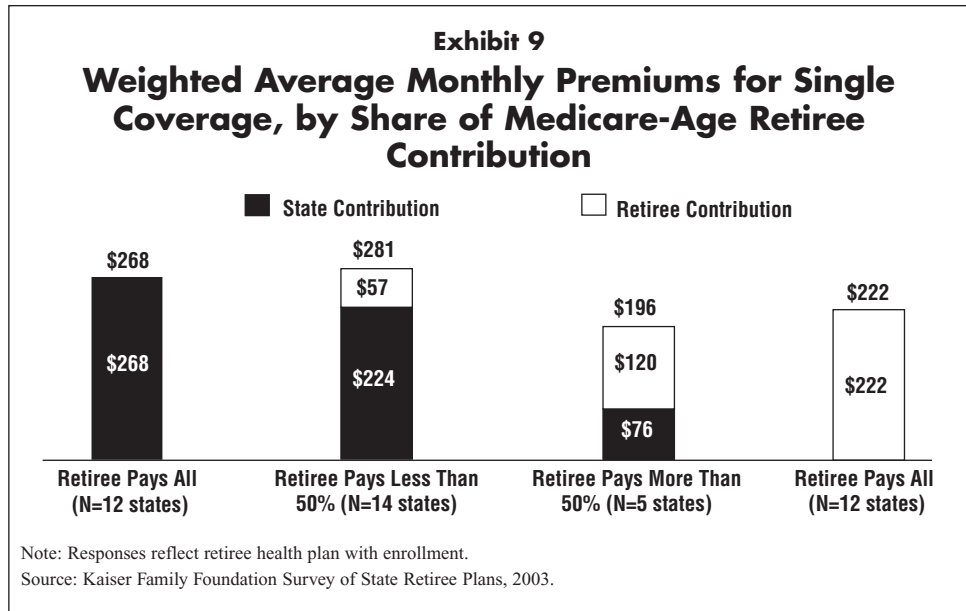
Total Premiums and Share of Premiums Paid by Medicare-Age Retirees

The total cost of retiree health benefits varies considerably by size of state, with total monthly premium costs averaging over a third more in the larger states than in the smaller states.⁷ The total 2002 monthly premium in the largest one-third of responding states was \$257 while in the smallest states, the total premium averaged \$189 per month (Exhibit 8). This difference may reflect higher overall health costs in these states. In the smallest states, retirees pay an average of \$103 per month, which amounts to a little over half of their premiums. This is more than state retirees pay in larger states, and reflects that about half of these small states require retirees to pay the entire premium. In the largest one-third of states, retirees pay only \$55 per month, less than one-fourth of the total premium cost. In almost half of these states, the state pays the entire premium.



There is a fair amount of variation among the states in the total cost of retiree health coverage. While the total 2002 premium for the largest plan in a majority of states ranges between about \$150 and \$250 per month, there are a few states where the premium for the largest plan falls well outside this range. In Indiana, for example, the total cost of coverage for its Medicare complement plan is \$105. South Dakota’s Medicare supplement costs \$110. Missouri’s health maintenance organization (HMO) costs \$133, Florida’s state PPO costs \$137, and Arizona’s Medicare+Choice plan costs \$137. At the other extreme, Alaska’s indemnity plan costs \$668 and West Virginia’s PPO costs \$406.

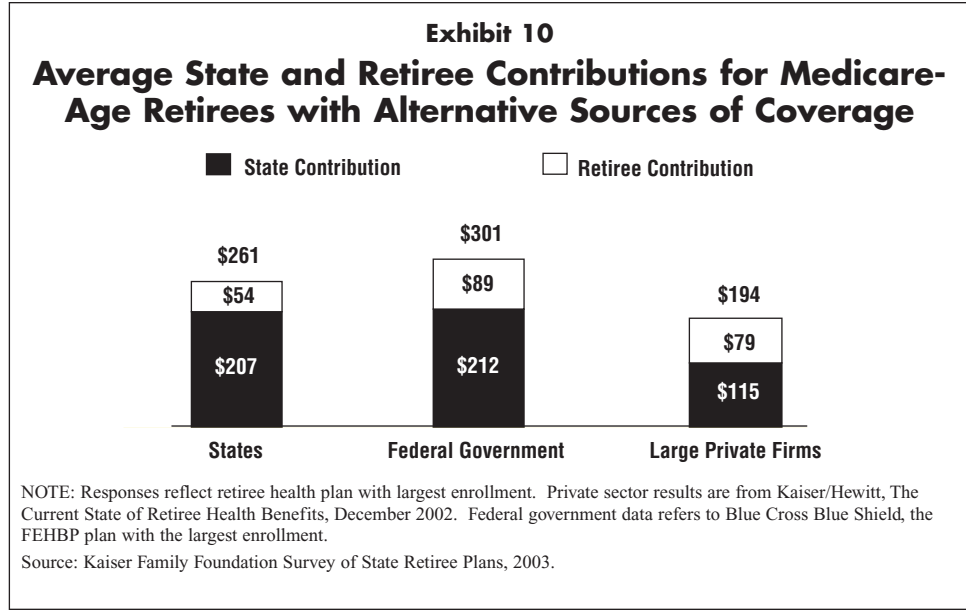
⁷ In this section, we initially present averages for three sets of states grouped by size (as measured by the number of Medicare-covered retirees in each state), rather than present one overall average that masks differences across states. Below, to simplify comparisons with alternative sources of coverage, we present the overall weighted average—which not surprisingly corresponds most closely to the numbers for the larger states. See the methodology appendix for a further discussion of issues in weighting.



Another way to observe the variation in premiums paid by Medicare-age retirees is by dividing states according to the relative premium shares paid by the states and the retirees (Exhibit 9). Retirees paying the entire premium spend an average of \$222 per month to get coverage, compared to \$57 per month in the states where retirees pay less than half the total premium (but at least some premium). Total premiums tend to be smaller in the states where the retiree pays a larger share of the premium—likely related to the tendency for smaller states to be in this category.

Comparing Retiree Share of Premium Across Alternative Sources of Coverage

The retiree’s weighted average share of the premium (\$54 per month) is somewhat less than that paid by workers in large, private-sector firms (\$79) (2002 Kaiser/Hewitt survey) (Exhibit 10).



Retirees in large, private firms pay more than state employees in large states (\$79 vs. \$55), but less than those in smaller states (\$79 vs. \$103). The total premium for large, private firms (\$194), however, is considerably less than the average for all states (\$261 per month).

If only those states are considered where the retiree actually pays some share of the premium (thus excluding the 12 states where the retiree pays nothing), the weighted average premium paid by the retiree is \$96. This amount is well above the average for all states and exceeds the average premium paid by retirees from large private firms (\$79).

Another way to put state retirees' premiums into context is to compare premiums for comparable coverage for federal retirees and for those who purchase private Medicare supplemental (Medigap) coverage. Under the federal plan with the largest enrollment (Blue Cross Blue Shield standard option), federal retirees in 2002 paid \$89 per month, considerably more than the average monthly premium share (\$54) paid by state government employees (Exhibit 10). Total cost of federal coverage at \$301 is also higher than the average state plan, but is comparable to the cost of coverage in the middle and largest states (California, New York, Texas).⁸

Medigap supplemental coverage is often the only supplemental insurance option for those who are not poor enough to qualify for coverage under Medicaid. A Medigap H policy, with coverage for drugs, can cost between \$150 and \$500 a month, depending on location, age, and health condition of the individual purchaser.⁹ The retiree whose monthly premium may average between \$55 and \$103, depending on the size of the state, has considerably lower costs than those shopping in the Medigap market. Furthermore, the drug coverage in an H policy is considerably less comprehensive than that found in nearly all state retiree health plans. In the 12 states where retirees pay the full cost of coverage, the comparison to Medigap premiums is closer (Exhibit 9). In those states, the retiree pays a weighted average monthly premium of \$222, still a modestly better deal than they would find in the Medigap market, which offers less comprehensive coverage.

Premiums Paid by Early Retirees

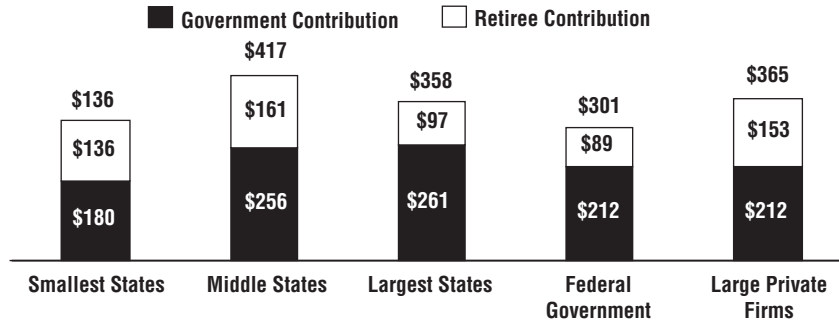
The total average premium (combining the retiree and state shares) for early retirees is considerably higher than the total premium for Medicare-age retirees (Exhibit 11), likely reflecting the fact that the state plan is the primary payer and not secondary to Medicare, as it generally is for retirees age 65 and older. In some states, early retirees are pooled with active employees, gaining the cost advantages of being pooled with younger, healthier individuals.

Early retirees typically pay more out of pocket for their coverage than do Medicare-age retirees. The early retirees' share of the premium is lowest in the larger states where they pay only about one-fourth of the total premium. Yet, this premium is 76 percent higher than that paid by Medicare-age retirees (\$97 versus \$55). In small states, early retirees pay an average of about 32 percent more than Medicare-age retirees (\$136 versus \$103). The highest premiums—both in terms of total premium and the share paid by the retiree—are found in the middle-size states. Early retirees, however, do not pay the \$58.70 monthly Medicare Part B premium, so their total premiums paid (to Medicare and to the state) are roughly comparable for both types of retirees.

⁸ Office of Personnel Management, 2002 FEHB Non-Postal Fee-for-Service Premium Rates, www.opm.gov/insure/health/02rates/nonpostal_ffs.htm

⁹ Weiss Ratings, Inc. "Rate of Medigap Premium Increases Slows Dramatically in 2002," Press Release, August 7, 2002 (and additional information on www.weissratings.com).

Exhibit 11
Average State and Retiree Contributions for Early Retirees with Single Coverage



NOTE: Responses reflect retiree health plan with largest enrollment. Private sector results are from Kaiser/Hewitt, *The Current State of Retiree Health Benefits*, December 2002. Federal government data refers to Blue Cross Blue Shield, the FEHBP plan with the largest enrollment.

Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

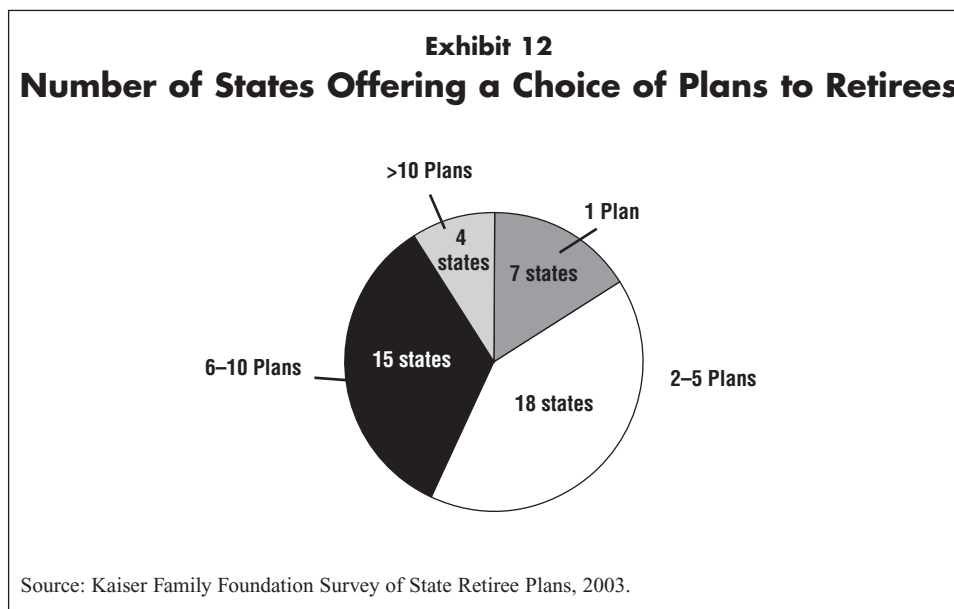
Generally early retirees from state governments pay somewhat less than early retirees from private firms (2002 Kaiser/Hewitt survey). Private firms' early retirees pay an average of \$153 per month versus averages of \$97 to \$161 per month, depending on the size of the state.

IV. Choice of Coverage

State retirees generally have a choice of several different types of plans, but enrollment is heavily concentrated in the less managed plans.

Choice of Plans

Most states (84 percent of the states, representing 88 percent of retirees) offer their retirees a choice of health plans (Exhibit 12). Typically, the states not offering a choice of plans are small states with relatively low enrollment. North Carolina is the exception, offering only a state-funded indemnity plan after its only HMO dropped out of the program. About 43 percent of states offer more than five plan options. States offering over 10 options include Colorado, Connecticut, Virginia, and Washington.



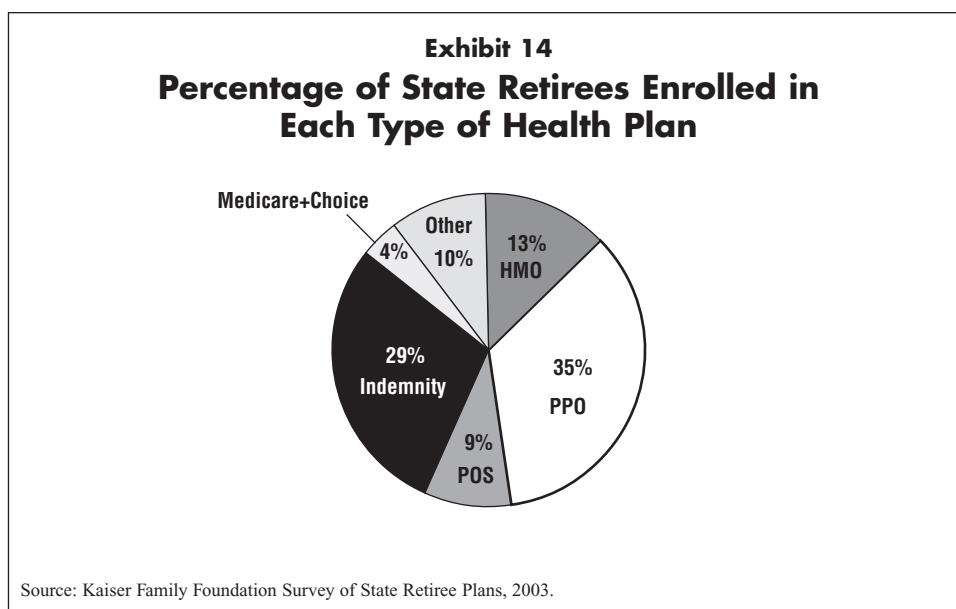
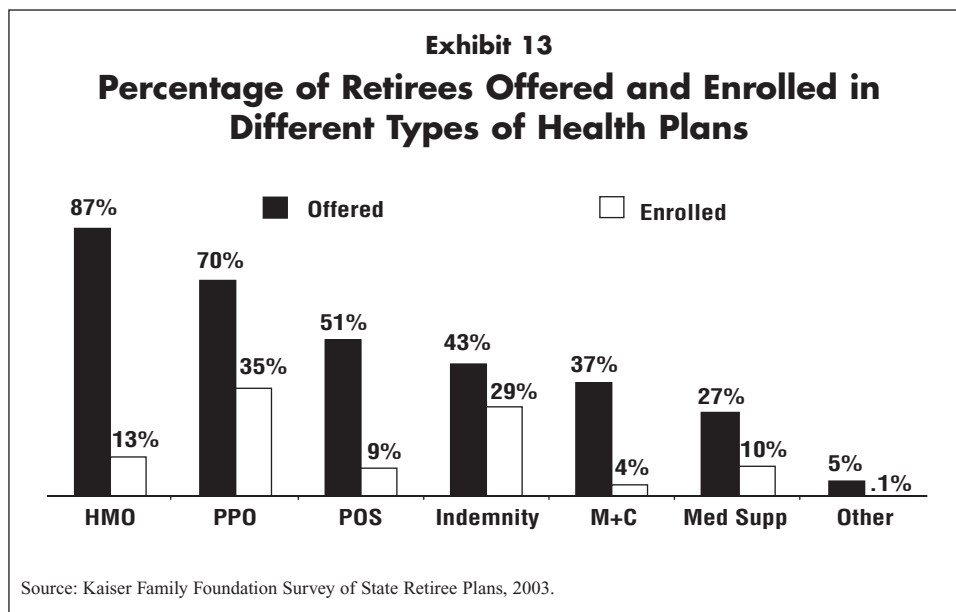
Every state offers some type of plan that has access to all providers (either an indemnity plan, a PPO, or a point-of-service plan), and about three-fourths of the states also offer an HMO option. In a typical state, the largest plan is either a PPO, an indemnity plan, or a Medicare supplement. From the perspective of retirees, about 87 percent have a choice of an HMO available to them, 43 percent have an indemnity plan, 70 percent have a PPO option, and 51 percent have a point-of-service option (Exhibit 13).

Compared to private-sector employers, states are more likely to offer a choice of plans. Whereas only 16 percent of states offer just a single plan, 26 percent of private firms offer a single plan to their early retirees and 40 percent have just one plan available for Medicare-age retirees (2002 Kaiser/Hewitt survey).

Enrollment by Plan Type

State government retirees seem to prefer traditional plans with less restricted networks. About one-third (29 percent) enrolled in indemnity plans and another third (35 percent) in PPOs (using weighted averages). Another nine percent enrolled in Medicare supplemental plans, which wrap around traditional Medicare and do not restrict choice of providers. Only about 13 percent of retirees are enrolled in HMOs, and even fewer in point-of-service plans (9 percent) (Exhibit 14).

Many of the larger states have at least 80 percent of their retirees in a single indemnity plan (e.g., Illinois, North Carolina, and Pennsylvania) or PPO (e.g., Florida, New York, and Ohio). By contrast, enrollment in California and Texas is more evenly distributed among several types of plans.



Role of Medicare+Choice in State Plans

Ten of the responding states partner with the federal Medicare+Choice program. In three states (Arizona, Oregon, and Washington), over one-third of retirees receive their state benefits through a Medicare+Choice plan.¹⁰ No states, however, require retirees to enroll in Medicare+Choice, although it is sometimes the case that Medicare-eligible retirees who choose a particular health plan are required to select the Medicare+Choice plan offered by that organization. There are always other non-Medicare+Choice options available for retirees. A couple of states that are not currently participating in Medicare+Choice volunteered that they are looking at options for the future, possibly including Medicare's new PPO demonstration.

¹⁰ California does not keep numbers for Medicare+Choice enrollment separately from overall HMO enrollment.

V. Benefits

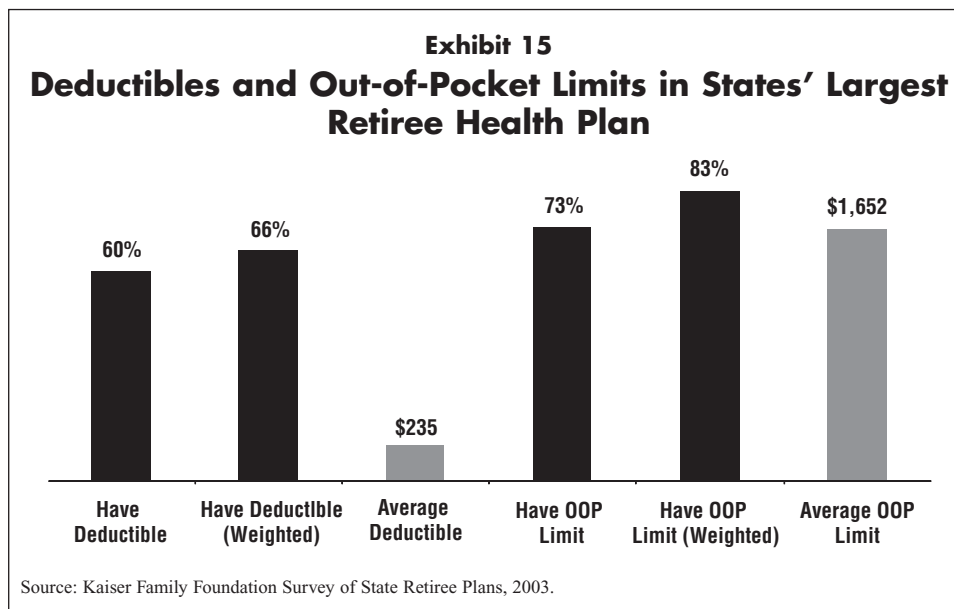
In general, the benefits offered to state government retirees are more generous than typical employer-sponsored benefits.

Plan Deductibles and Limits on Out-of-Pocket Costs

The largest plans in about 60 percent of the states have a deductible, averaging \$235 per person. About 73 percent of the states include a limit on annual out-of-pocket costs, averaging just over \$1,650 per person (Exhibit 15). In large states, plans with the greatest enrollment are slightly more likely to have deductibles and out-of-pocket limits.

Several of the states that do not have deductibles or out-of-pocket limits have Medicare supplemental plans as their largest plan for Medicare-age retirees. Since these plans typically wrap around Medicare coverage, a deductible is not required. Because these supplemental policies generally cover most of the out-of-pocket costs not covered by Medicare, an out-of-pocket limit is typically not needed.

There is considerable variation among the states. Wyoming, for example, has a deductible of \$750 in its only retiree health plan, with a limit on out-of-pocket costs set at \$10,000 per person, whereas Ohio has a deductible of \$100 and an out-of-pocket limit of \$500 per person in its PPO.



VI. Prescription Drug Benefits

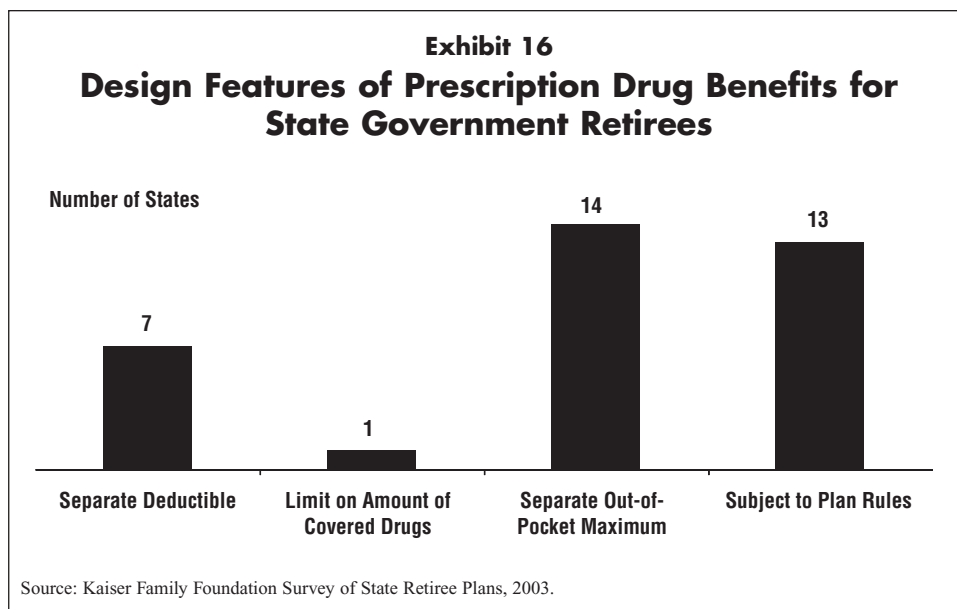
Prescription drugs are an increasingly important part of the benefit package for retirees, especially for Medicare-age retirees who do not currently have a drug benefit as part of their Medicare coverage. Although the states are generous in the drug benefits they offer, they report they have taken steps to contain the cost of this benefit.

Availability of a Prescription Drug Benefit

Every state includes a prescription drug benefit in the health plans offered to retirees, similar to the findings for large, private-sector firms (2002 Kaiser/Hewitt Survey). While in most states, each plan integrates drug coverage with coverage for other services, about one-fourth of states carve out drugs separately.

Design of Prescription Drug Benefits

The drug benefits offered by states are rather generous, with only one state (Tennessee) limiting the amount of drugs covered (Exhibit 16). Tennessee's plan with the largest number of Medicare enrollees is a Medigap standard plan H with a \$250 deductible for drugs and 50 percent coinsurance up to a limit of \$1,250 in payments for drugs. A total of seven states impose a separate deductible for drugs. These deductibles average about \$100 and range from \$25 to \$250. A total of 14 states limit out-of-pocket cost-sharing for drugs, with an average limit of just over \$1,000. This average masks some wide variation. Wisconsin and Iowa have low limits of \$240 and \$250, respectively, while Kansas and North Carolina top the list at \$2,100 and \$2,500. The remaining states do not have any limit on out-of-pocket spending for drugs, although in some cases overall limits do apply.

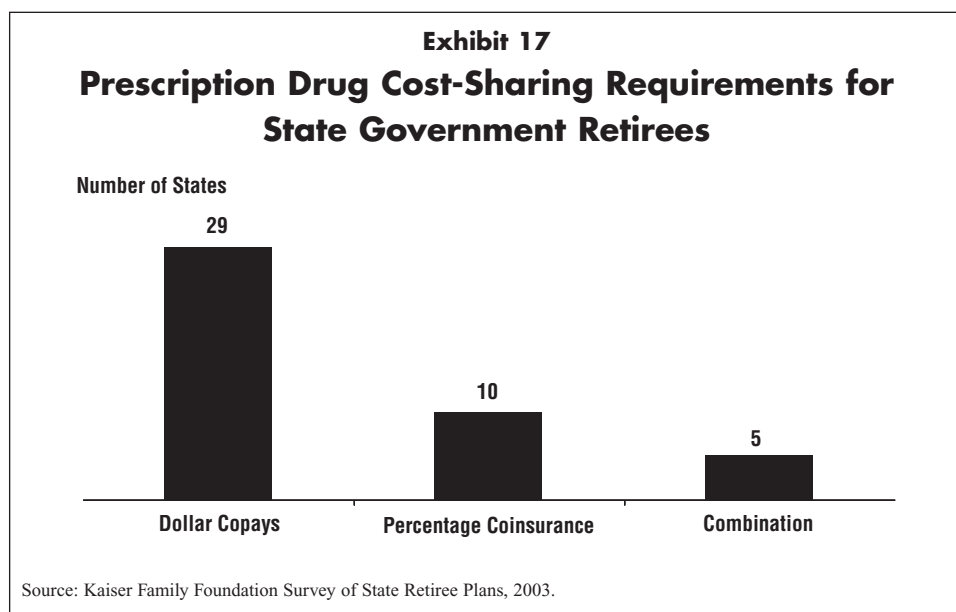


Availability of Mail-Order for Drugs

Typically, states provide coverage for drugs purchased at retail pharmacies and through mail-order pharmacies, but eight states cover only drugs purchased at retail pharmacies. States are more likely to make this choice than are private firms (18 percent of states versus 6 percent of private firms, according to the 2002 Kaiser/Hewitt survey). Some respondents noted that this choice reflected the political clout of their state’s retail pharmacies. When mail-order pharmacies are located out of state, policymakers may be reluctant to take business away from in-state providers. Generally, where mail-order is available, retirees are offered incentives in the form of lower cost-sharing to buy maintenance drugs by mail. No state requires use of mail-order.

Cost-Sharing for Drugs

Most states apply a two-tiered or three-tiered system of copayments for prescription drugs, while 10 states use coinsurance percentages that range from 10 to 50 percent. A few states use some combination of the two methods of cost-sharing (Exhibit 17). Three-tiered cost-sharing is used in half of the responding states (Exhibit 18). Two states have just a single flat copayment—Pennsylvania (\$7 per retail prescription) and Virginia (\$27).



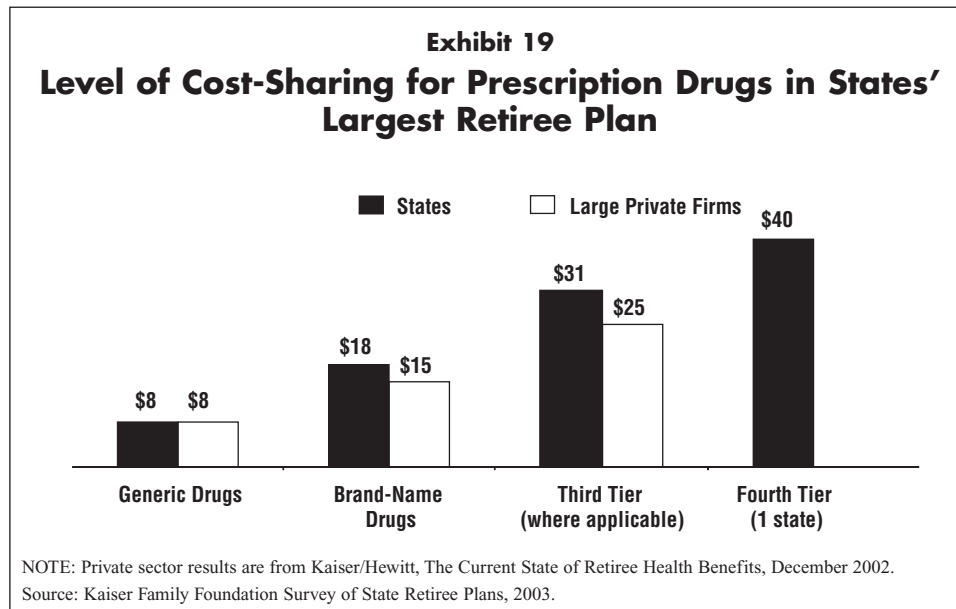
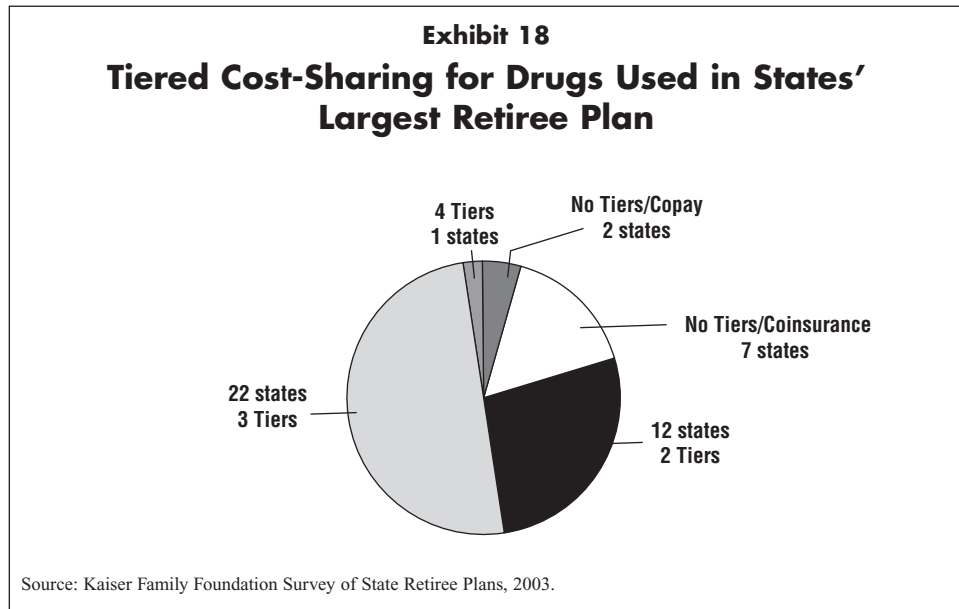
The average three-tier copayment structure charges \$8 for generic drugs, \$18 for preferred brand-name drugs, and \$31 for non-preferred drugs—levels quite similar to those applied by large, private-sector employers participating in the 2002 Kaiser/Hewitt Study (Exhibit 19). Again, there is considerable variation. New York’s two-tier system has copayments of \$5 and \$15, while North Carolina uses a four-tier system with copayments of \$10, \$25, \$35, and \$40 (the two middle tiers representing preferred brand drugs with or without an available generic alternative and the fourth tier representing non-preferred drugs).

Among the states that use percentage coinsurance for their cost-sharing, a few states tier their coinsurance. For example, Kansas uses levels of 20 percent, 30 percent, and 50 percent, with special provisions for lifestyle drugs and so-called “special case” drugs. By contrast, Oregon

has a single level of 50 percent coinsurance, with a cap per drug set at \$150. Some of the states that use a single coinsurance rate note the natural tiering inherent in the use of a percentage coinsurance.

Indiana has a variation based on whether retirees fill their prescriptions at participating pharmacies. The two-tiered coinsurance rate is 10 percent and 20 percent at participating pharmacies, but 30 percent and 40 percent at nonparticipating pharmacies.

At least 11 states go a step further in an effort to encourage the use of generic drugs and charge the beneficiary the full difference between the cost of a brand-name drug and an equivalent generic drug, when there is a generic available.¹¹



¹¹ There may be more than 11 states with this policy, since this question was a volunteered response not asked on the survey. We have reviewed plan descriptions to get this information on as many states as possible.

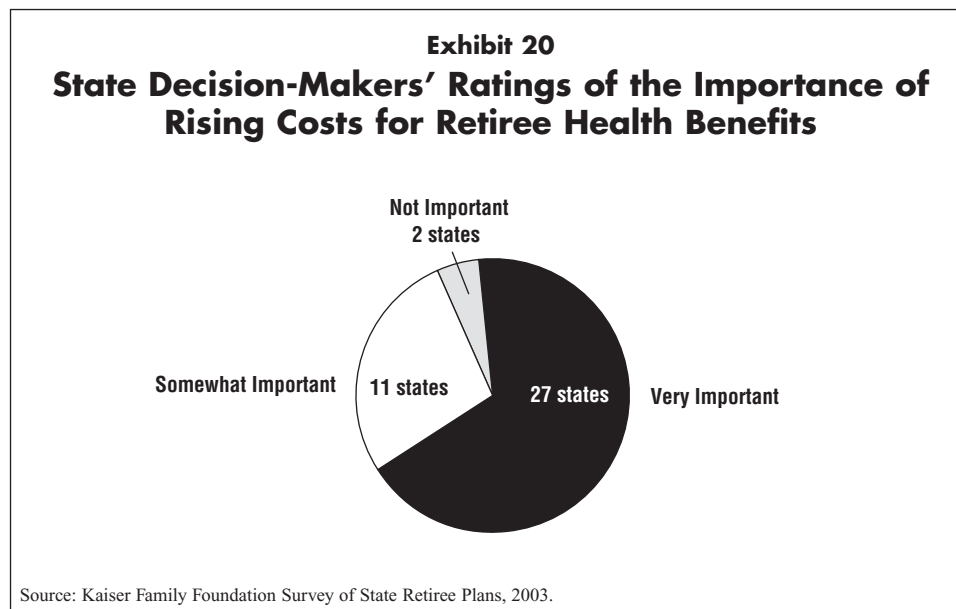
VII. Budgetary Pressures Facing States and Their Subsequent Responses

The states, in their role as employers, are feeling the pressures of rising health costs. Drug costs are clearly a major contributor to this pressure, and many states have responded by taking specific steps to slow the growth in spending in general and especially the rise in drug spending.

Budgetary Pressures

Two-thirds of responding states called the issue of health costs “very important” (whether responding about its impact on state budgets or on the retirees for those states who pay none of the costs) (Exhibit 20). Just over half of the states reported that the issue had received specific attention from the governor in the last two years, and a similar number reported that legislative hearings had been held on the subject. This level of concern is similar to that expressed by private-sector firms in the 2002 Kaiser/Hewitt survey, where 52 percent of chief executive officers were reported to be very concerned about retiree health costs.

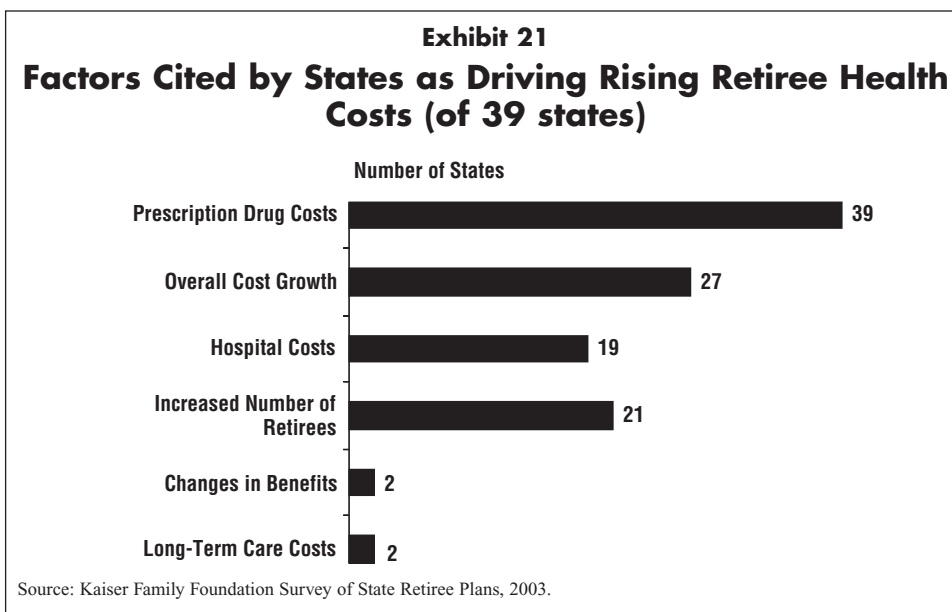
Average annual total cost increases were about 15 percent (about two-thirds of the states that incurred expenses were not able to provide an estimated rate of growth for either retiree costs or total employee costs).¹² This rate of growth is similar to that experienced in the private sector. The 2002 Kaiser/Hewitt survey reported an average 16 percent growth rate between 2001 and 2002, with slightly lower growth rates for larger firms.



¹² This average rate of growth represents a combined average derived from 16 states that were able to provide a growth rate for retiree health benefits separately (average of 16.5 percent) and from 11 states that could only provide a combined growth rate for health benefits for both active employees and retirees (average of 14 percent). The remaining states either could not provide a growth rate, or told us that the growth rate was not applicable because the retirees paid the entire cost of coverage.

Factors Driving Growth of Retiree Health Spending

Every state that responded to a question about the most important factors driving the growth in state retiree health spending cited the rise in prescription drug spending as one of the key factors. Over half of the states also cited the overall growth in health costs, and about half cited either the increased number of retirees or the growth in hospital spending (Exhibit 21). The frequent mention of prescription drug spending is not surprising given that most state retirees rely on their employer-sponsored retiree benefits to help pay for their drugs in the absence of a Medicare drug benefit. In fact, one state noted that about 45 percent of its total retiree costs were for prescription drugs. By contrast, changes to the benefit package or growth in long-term costs were rarely cited as key drivers of retiree cost growth.

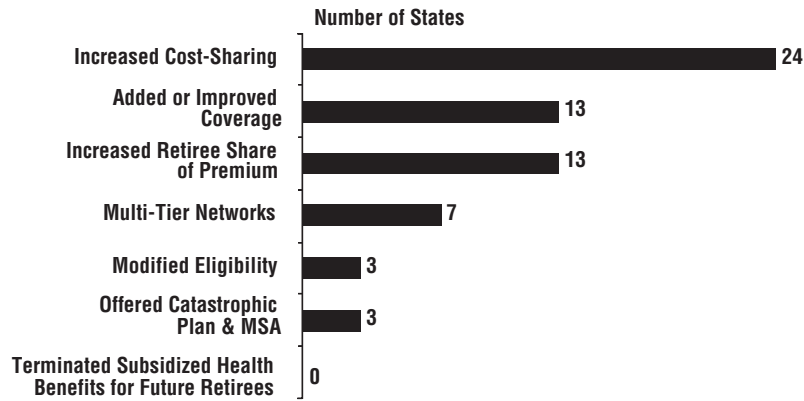


Actions Already Taken to Control Costs

Over half of responding states say they have conducted negotiations with health plans and providers to reduce costs. Also, about one-third of the states have created a special task force to address these issues and determine what actions to take. Overall, nearly every state has taken some kind of action to control costs, including changes to benefits or administrative procedures or higher cost-sharing requirements for their retirees. However, no states have terminated subsidized health benefits for current or future retirees.

Although most of the changes that states have made in the past two years have addressed drug benefits, a majority of states took measures to increase cost-sharing for other services, as well (Exhibit 22). About a third of the states took some steps to add or improve coverage at the same time as they worried about the cost of coverage. Only a handful of states, however, took steps to implement multi-tier networks, offer a catastrophic health benefits plan, or modify their eligibility requirements.

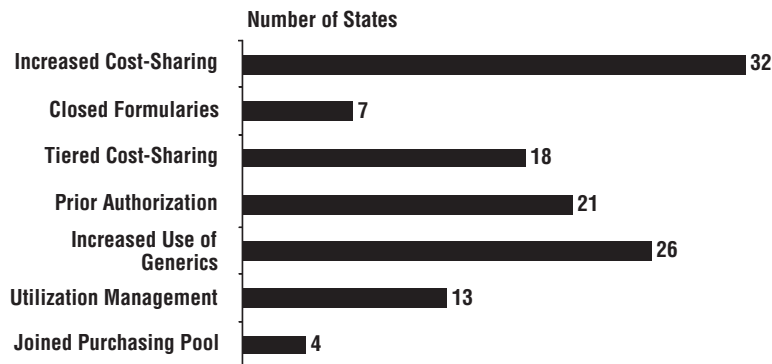
Exhibit 22
States Making Specific Changes to Retiree Health Coverage in Past Two Years



Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

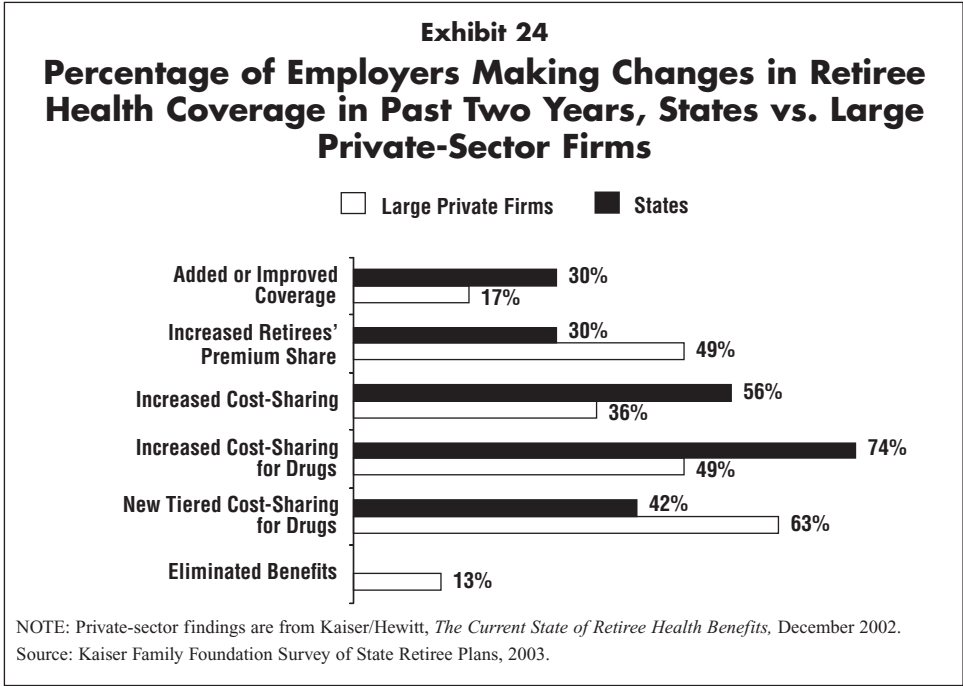
In terms of drug benefits, more than half of the states that responded increased cost-sharing for drugs and took specific steps to increase use of generic drugs (Exhibit 23). Nearly half of the states reported adding requirements for prior authorization for certain drugs or adding or expanding their use of tiered cost-sharing. Smaller numbers of states have acted to implement new utilization management programs, implement closed formularies, or join purchasing pools. In most cases, the changes they reported were made for active workers as well as retirees.

Exhibit 23
States Making Specific Changes to Retiree Drug Coverage in Past Two Years



Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

Compared to the states, large private firms were less likely to add or improve coverage or to increase cost-sharing for drugs or other health benefits (2002 Kaiser/Hewitt Survey). But the private firms were more likely to increase their retirees' share of premiums, to implement new tiered cost-sharing approaches for drugs, and to entirely eliminate subsidized benefits for future retirees (Exhibit 24).

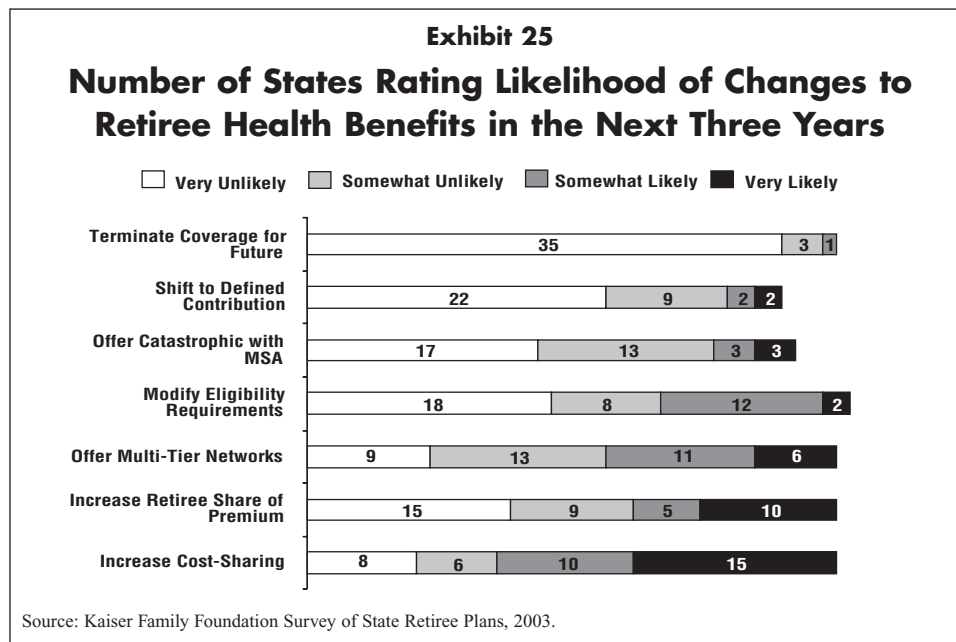


VIII. Changes Anticipated in the Future

States expect to continue making adjustments to their benefits to keep control of rising costs in the near future. But the clear expectation is that they will not be making dramatic changes such as eliminating benefits entirely, as more commonly observed in the private sector. Since prescription drugs are viewed as the largest source of cost pressure, they are the most likely targets for change.

Anticipated Health Benefits Changes

Looking ahead to the next three years, the only changes (other than those relating to prescription drug benefits) that state program officials say are likely to occur are increases in beneficiary cost-sharing requirements (Exhibit 25). Other measures that are regarded as possibilities in some states are increased retiree contributions toward premiums, offering of multi-tier networks, and modifications to the eligibility requirements for coverage.

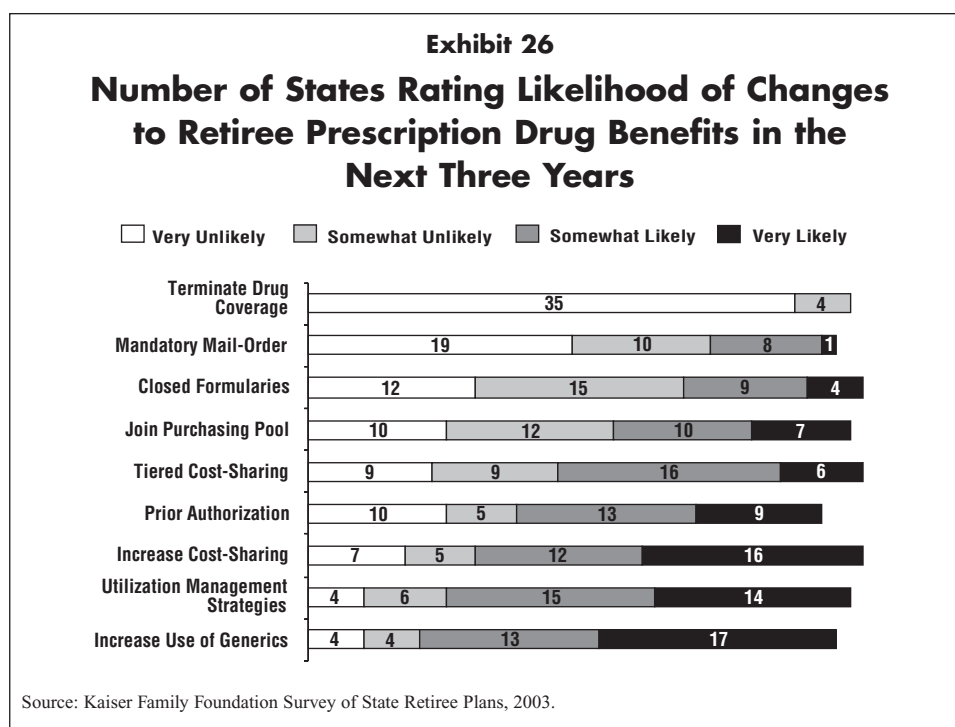


State do not appear to be giving serious consideration to eliminating the benefits they currently offer to their retiree population. In fact, several states, when asked about the likelihood of terminating benefits for either current or future retirees, wanted a stronger response category than “very unlikely.” Whereas 22 percent of large, private firms in the Kaiser/Hewitt study said they were very or somewhat likely to terminate all subsidized health benefits for future retirees, only one state suggested that option was “somewhat likely.”

Other options that appeared totally off the table for most states were shifting to a defined contribution approach and offering medical savings accounts with catastrophic insurance—both strategies that large, private-sector employers in the 2002 Kaiser/Hewitt study identified as potential ways to control the growth in retiree health spending.

Anticipated Prescription Drug Benefits Changes

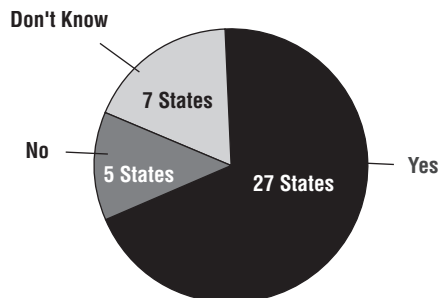
Prescription drugs are the major source of cost pressures and represent the area where future changes are most often anticipated. State administrators see a number of likely changes in the area of drug benefits over the next three years (Exhibit 26). At least two-thirds of the states expect to implement new incentives to increase use of generic drugs and to ask for higher copayments for brand-name drugs. About half of the states say they are at least somewhat likely to increase their use of prior authorization requirements and utilization management strategies for certain pharmaceuticals, to make further moves toward tiered cost-sharing, and to take what steps they can to get lower prices for drugs. But most states are unlikely to move to closed formularies or mandatory mail-order, as is expected among private employers. Similar to private employers, states look unlikely to drop their drug benefits altogether.



The Potential Impact of a Medicare Drug Benefit

When asked to speculate on what would happen if the Congress were to enact a Medicare prescription drug benefit, nearly three-fourths of the states said they thought they would save money (Exhibit 27). This speculation could obviously change depending on the specific details of any final drug bill that Congress might pass into law. Most anticipate that they would retain their coverage as a supplement to whatever Medicare offered, similar to how they handle other benefits (Exhibit 28). They prefer this approach to dropping all drug coverage or to retaining coverage with a federal subsidy, should one be available.

Exhibit 27
States Expecting to Save Money if a Medicare Drug Benefit Were Enacted

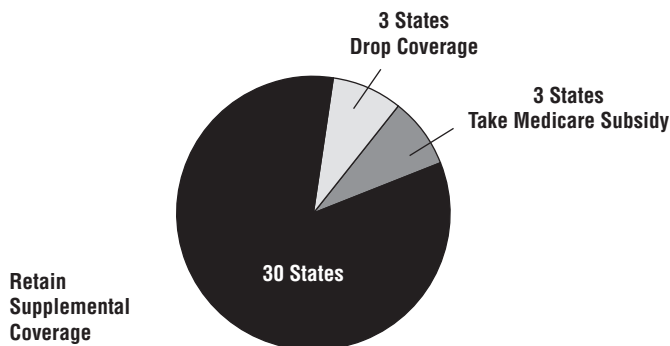


Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

How States Make Changes to Their Benefits

As states think about whether to make changes to their retiree health benefits programs, their decision-making processes appear quite different than those of private firms. They share with many large firms the constraint imposed by union contracts, since employee unions play an active role in many states' benefit negotiations. Many states make an effort to keep coverage for retirees and active employees comparable. While some states have entirely different benefit systems for the two groups, many keep the benefit packages parallel even if they have different approaches to how premium costs are distributed. Generally, states are likely to face more procedural hurdles than firms in the private sector. About half the states reported that some portion of the benefit design is created in statute so that major changes require legislative action. Still, 22 of 41 responding states called administrative action the most common process for making changes, followed by union negotiations (9 states) and legislation (6 states).

Exhibit 28
Expected State Reactions if a Medicare Drug Benefit Were Enacted



Source: Kaiser Family Foundation Survey of State Retiree Plans, 2003.

IX. Conclusion and Policy Implications

In general, states operate a generous system of health benefits for their retirees. Like their private-sector counterparts, state retiree health programs are facing growing cost pressures. Yet unlike employers in the private sector, states uniformly anticipate that they will continue to offer retiree health benefits in the future. No states appear to be giving serious consideration to eliminating retiree health benefits.

Similar to other employers, most states see retiree health benefits as an important factor in their ability to hire and retain their workforce. But unlike private-sector employers, state governments may face political pressure to protect employee and retiree benefits. State workforces, whether unionized or not, can be a formidable influence in state legislatures. Some administrators volunteered that since salaries for state employees often do not match those of private-sector employers, employee benefits are seen as a key component of the total compensation package. Additionally, state workers are more likely to maintain a long career in state government than are workers with a particular employer in the private sector, and thus a generous health benefits package is viewed as compensation for dedication and years of service.

The potential impact of new rules that are being considered by the Government Accounting Standards Board (GASB) could have a major impact on state retiree health costs. Like the rules implemented by its private-sector counterpart (Financial Accounting Standards Board), GASB is considering a requirement that governments include in their financial statements their future obligations to pay for retirees' health costs and how they plan to meet those obligations. Such a requirement would likely put new pressure on states to manage costs differently in their retiree health systems, possibly forcing more stringent changes in benefits and costs.

Strained budgets and pressures from the combination of rising costs, a weaker economy, and the legal requirement of a balanced budget are among the biggest concerns for states this year. State retirees will certainly be affected by this environment, with the possibility of increased out-of-pocket costs and increased management strategies, such as prior authorization for certain drugs and other services, a distinct possibility. The good news for state retirees is that they are likely to remain in a strong position to avoid more drastic changes at this time. The bad news is that they are likely to assume a greater share of health care costs in the future.

Appendix: Methodology

Telephone interviews with state officials administering retiree health programs were the principal source of data for this study. The 54-question protocol included sections on eligibility, plan options, benefits offered, state and retiree contributions to premiums, budgetary pressures, changes made recently, and changes anticipated in the future. The protocol was designed mostly for closed-ended responses. Respondents were provided with a questionnaire in advance, so that basic plan information could be collected before the interview.

Responses were sought from all 50 states and the District of Columbia, with an initial letter directed at the principal official identified as responsible for administering retiree health benefits. In a few cases where scheduling a telephone interview proved difficult, states were permitted to complete the questionnaire in writing, with any necessary clarifications obtained by a follow-up telephone or email. In two of the latter cases, the state provided brochures and other documentation from which some responses were derived. In all cases, plan brochures and other explanatory materials were collected either by mail or from state websites. That detailed information was compared to the responses. Where possible, inconsistencies were addressed through follow-up questions.

In total, responses were obtained from 43 states and the District of Columbia (37 by telephone and 7 in writing). The interviews were conducted between July and October of 2002; telephone interviews generally required between 20 minutes and one hour. The seven remaining states (Delaware, Georgia, Hawaii, Michigan, Mississippi, New Mexico, and Rhode Island) either did not respond to repeated inquiries or declined because of insufficient staff time.

In general, respondents were asked to report information that applied for individuals enrolling in plans at the beginning of 2002. Where plan options or premiums varied according to when someone retired, state officials were asked to respond based on individuals who retired on or after January 1, 2002, with full eligibility in terms of age and years of service. Where plan options or premiums varied by location within a state, respondents were directed to answer for the location with the largest number of retirees. For questions regarding benefits and premiums, respondents were asked to provide information on the plan with the largest number of retirees (and where appropriate, for both the plan with the largest number of retirees enrolled in Medicare and the plan with largest number of retirees not enrolled in Medicare).

Counting dependents, there are about 1.8 million covered lives represented by the entities (43 states and the District of Columbia) that responded to the survey. This projects to about two million covered lives in the 50 states (and the District of Columbia). Since some states maintain separate systems for covering local government employees and schoolteachers, the total number of covered lives in state-based systems is estimated to be at least 2.25 million.

Specific Data Caveats

Several issues were discovered in reporting the number of retirees participating in the system of health benefits. While many states could report separately the number of retirees and number of active employees participating in the system, not all could make this distinction. A total of eight states could not estimate the number of retirees who have Medicare coverage versus those who lack such coverage. Where necessary for purposes of national counts, these splits were estimated using averages from all other states. An even larger number of states could not provide good estimates of the number of dependents with coverage or the Medicare status of dependents. States also differ in how they report information about their programs. Some administer benefits for groups such as teachers separately and only reported data on their core population of state employees. Others operate all groups under the same system, and report overall totals. Readers should keep these differences in mind when interpreting results.

Similar issues arose in reporting the number of beneficiaries by plan type. Some states do not routinely prepare such summary totals, or at least do not separate for retirees and active employees. Where necessary for summary purposes, estimates were made from the best available information.

Reporting on who is eligible for benefits is a challenging area since retirement eligibility is managed by a separate agency in many states. In those cases, the agency administering health benefits may simply accept a person who receives a pension as eligible for health benefits. Where possible, information was obtained from state retirement brochures and websites to report on eligibility. But it is also noted that eligibility rules in some states are quite complex, with eligibility for certain categories of employees differing from that for others.

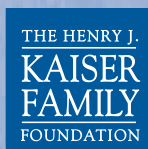
In general, data on benefits and premiums were collected for the health plan with the largest number of retirees. Where separate plans were offered for early retirees and Medicare-age retirees, respondents were asked about the largest plan in each category. In some states, benefits are standardized across plans, but in others there may be significant differences among the available plans. Readers should be aware of these differences. Simplified summary language may sometimes allow the inference that a certain characteristic occurs for some percentage of states or retirees, when in fact it only applies to the subset of employees enrolled in the largest plan.

Weighting

No weighting scheme offers the perfect solution for how to represent certain characteristics, such as the premium paid by a retiree or the entire premium paid on the retiree's behalf, by a single average. An average that weights each state equally gives more prominence to small states and fails to recognize that most retirees get benefits from a few of the largest states. But an average weighted by the number of retirees does not fully recognize the fact that premium and benefit data were collected for plans serving the largest number of retirees. In some states, all or nearly all retirees are enrolled in a single plan, whereas in a few states the largest plan has fewer than half of all retirees. Data were collected directly on the number of

retirees in the largest plan. But even if weights were based on estimates of that number, this approach leaves out retirees in other plans whose benefits may be nearly identical. Compounding these concerns, any weighting scheme is affected by the reporting issues noted above.

To address the weighting issue for analyzing the cost of retiree coverage (Section III), separate averages were calculated for small, medium, and large-sized states. States were ranked by their estimated number of Medicare-covered retirees, and then grouped so that equal numbers of states were included in each of three categories. In several cases, this approach reveals interesting differences between the different types of states. Elsewhere, averages are reported either counting all states equally or weighting according to the total number of retirees in the state. Where the latter approach was chosen, it was done so because these numbers appear to be reported more consistently and more accurately than most of the alternatives.



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